TEXAS HIV HEALTH INSURANCE OPTIONS (THHIO)

PURPOSE

This policy outlines the Texas HIV Health Insurance Options (THHIO) paid from client service contracts awarded to various contractors by the Texas Department of Health (TDH), Bureau of HIV and STD Prevention (Bureau). THHIO is intended to assist eligible HIV positive individuals with their health insurance premiums and medical treatment deductibles and co-payments. The policy also discusses other types of health insurance assistance available to persons who are HIV positive and have a variety of insurance needs.

BACKGROUND

Many HIV positive individuals are unable to continue their work due to the progressively debilitating nature of HIV disease. These individuals are faced with the prospect of losing their employer-sponsored group medical insurance because they are unable to pay the premiums for such coverage and/or their deductibles or co-payments. Other HIV positive individuals may be unable to afford the cost of an individual insurance policy because of declining income and the high costs of covering pre-existing conditions. One way the Bureau fulfills its mission of treating and preventing HIV disease is to assist qualified HIV infected persons in paying for their insurance premiums and deductibles or co-payments associated with medical costs. This action maintains the level of care the individual needs while avoiding costs that would have to be taken from state and federal funds for full-cost treatment and drug therapy.

AUTHORITY

Ryan White CARE Act, 42 U.S.C. §300ff-25

DEFINITIONS

Beneficiary	a person listed and insured on a health or dental insurance policy
Co-payment	(or co-pay) is a cost sharing arrangement in which a covered person pays a specified charge for specified services or medicine, such as $10 for an office visit or $5 for a prescription
Deductible	the amount of money that some insurance policies require the policy holder to pay before policy benefits will begin covering costs
Earned income	money that eligible members of the family earn through employment or self-employment

Family	a group of two or more persons who are beneficiaries listed on a common health insurance policy. Beneficiaries may be related by birth, marriage or adoption or they may be unrelated. All such persons are considered as members of one family provided the family member is not compensated for providing care to the person with HIV
Legally responsible person	a parent, managing conservator, or other person that is legally responsible for the support of a minor, a ward, or himself/herself
Premium	the money paid to an insurance company to purchase medical or dental insurance usually prepaid on a monthly or quarterly basis
Primary insured Person	the individual in whose name the health insurance policy is written, or who is considered to be the primary cardholder in the case of group insurance
Unearned income	money that eligible members of the household receive from Social Security, veterans benefits, retirement, or some other similar source where the recipient is not employed in return for money

GENERAL REQUIREMENTS

HIV Assemblies are expected to allocate funds to maintain THHIO within the HIV Services Delivery Area (HSDA) according to the needs identified in local needs assessments. The Bureau requires the needs assessment to be more than a simple client survey. Assemblies are expected to set aside a percentage of Ryan White Title II funds for clients within the HSDA who are in need of financial assistance to help pay for insurance premiums, co-payments or medical deductibles. State HIV Health and Social Services funds may also be used for this purpose.

Assemblies must request a waiver from the Bureau and provide written justification for not making THHIO available in the HSDA if such an option is desired. The Bureau will review each waiver and either accept or reject it based on needs assessment data for the HSDA served by the Assembly. Sufficient documentation must be provided to justify a waiver.

BUREAU EXPECTATIONS REGARDING PROGRAM OPERATION

THHIO may only be used to pay the co-payments and deductible payments for eligible HIV infected person.

Total payments per client

Total payments for premiums, deductibles, and co-payments for each HIV infected person may not exceed $750 per client per month. A provider may apply for a waiver of this requirement with the Bureau's Field Operations Branch to accommodate special situations or needs.

Payments allowed from THHIO

Funds from THHIO may be used to pay the premium to provide new insurance coverage for an eligible person. THHIO funds may also be used to pay the on-going premiums for medical and/or dental insurance coverage and co-payments/deductibles for medical treatment or dental care for the HIV-infected client. In addition, program funds may be used to pay costs, such as deductibles, co-payments or premiums, that Medicare or Medicaid do not pay.

Prorating THHIO premium payments

The amount of payment that may be made from THHIO for the insurance premium varies according to which beneficiary in the family is HIV infected, how many beneficiaries in the family are covered under the common health insurance policy with the HIV infected person, and how much is paid for the insurance premium. Should a family possess more than one health insurance policy, THHIO payments may only be made to the insurance policy covering the HIV infected person(s). Additional policies covering uninfected family members have no bearing on computing THHIO payments.

In many cases the employer pays for that portion of the insurance premium necessary to cover the primary insured person. The primary insured person must pay the premium for additional beneficiaries. For policies where the employer pays for coverage of the primary insured person, the amount of the employer-paid benefit is not reimbursable under THHIO.

THHIO payments are computed to ensure that payments are only made for each HIV infected family member. Therefore, the general rule is to subtract that portion of the insurance premium that is attributable to the family member who is **NOT** HIV infected from the total insurance premium.

The THHIO PAYMENT TABLE attached at the end of this policy may be used as a guide to determine insurance premium payments made from THHIO.

TYPES OF PAYMENTS THAT MAY NOT BE MADE FROM THHIO

Grant funds may not be used to make payments for any item or service to the extent that payment has been (or can reasonably be expected to be made) under the following:

- an insurance policy
- the Texas Health Insurance Risk Pool
- federal or state health benefits programs
- any amount expended by the state under Medicaid, or
- by an entity that provides health services on a prepaid basis

BASIC THHIO OPERATING REQUIREMENTS

Application, intake, and follow-up process

Each agency operating THHIO, in cooperation with case management agencies operating within the HSDA, is to establish a method by which an HIV infected client or legally responsible person may contact a case manager in the HSDA, file an application for THHIO, provide documentation, and receive appropriate coordination and follow-up. The case manager should determine the client's eligibility as soon as becoming aware of the impending need for insurance assistance to avoid a break in coverage.

THHIO providers and cooperating case management providers are expected to be proactive in identifying clients with insurance assistance needs. Clients should be made aware of insurance assistance at initial intake and periodically thereafter, and have their eligibility assessed for assistance as appropriate.

Client enrollment in THHIO must be readily accessible through a local provider, an entity providing case management services in the HSDA, or an entity that has a cooperative agreement with case management provider(s). Application intake, documentation of eligibility, follow-up activities, and coordination are considered to be part of the case management process. Clients should provide a written release to enable the THHIO provider and medical providers/insurance carriers to interact as needed to provide services.

Assemblies may establish other criteria in their request for proposals that will be included as part of its agreement with the entity providing case management services. The criteria may include such things as the frequency of client contact that is expected to be performed by the case manager, and case manager interaction with the entity responsible for making THHIO payments.

The actual method of providing the service may include using a provider in the HSDA that administers the program in part or in its entirety. An Assembly may determine if an organization in another HSDA is capable of making payments, tracking expenditures, and monitoring other facets of the program. If such an organization is available, the Assembly may contract with that organization to provide services other than those that must take place in the HSDA.

Monthly health insurance premiums must be paid directly to the client's insurance carrier and/or provider. Reimbursements for medical premiums, co-payments or deductibles may not be made directly to the client. Medical providers may send bills for

deductibles or co-payments to the entity responsible for dispersing THHIO funds for reimbursement.

NOTE: There are occasions when partial refunds for premiums paid on behalf of a client may be due. Case managers should pursue such refunds that may be returned to budgets set aside for THHIO.

ELIGIBILITY CRITERIA

The list below shows the basic eligibility factors for THHIO. These factors must be applied uniformly to all clients. To be eligible, the client:

- may be employed or unemployed
- must be diagnosed as having HIV infection or AIDS, and
- annual family gross earned and/or unearned income may not exceed 300% of the federal poverty guidelines according to family size

Individuals who are eligible for the Temporary Assistance to Needy Families and/or the Food Stamp Program will have already had an income assessment completed. Individuals who provide documentation showing their eligibility for one of these programs may be considered eligible for insurance assistance because their eligibility is based on 100% of the federal poverty limits. When individuals do not have documentation, the case manager may verify eligibility with the local office of the Texas Department of Human Services with permission of the client.

OTHER RESOURCES OR OPTIONS AVAILABLE TO THE CASE MANAGER

To assure a continuum of health insurance, the case manager should consider using other programs or options to ensure that the client will not experience an interruption in coverage. Some of the resources or options available to assist the client include:

- Federal; Combined Omnibus Budge Reconciliation Act (COBRA)
- Texas HIV Medication Program - Texas Department of Health
- Texas Health Insurance Risk Pool – Texas Department of Insurance (TDI)
- Texas Healthy Kids Corporation (THKC) – 1-800-943-KIDS (5437)
- Medicaid – the local Texas Department of Human Services office
- Medicare – Social Security Administration
- Health Insurance Portability and Accountability Act of 1996
- Long-term care insurance – contact a lawyer and/or insurance agent for information
- Medical Savings Accounts (MSAs) – contact a lawyer and/or insurance agent for information
- Accelerated death benefits and viatical settlements – contact a lawyer and/or insurance agent for information

COBRA benefits

When an individual loses a job and worked for a business that has 20 or more employees, the individual and/or their beneficiaries may be eligible to keep the employer's insurance for 18 to 36 months. The affected person must opt for COBRA coverage within 60 days of leaving the job. The individual who takes this coverage pays the full premium, plus an administrative fee. Certain persons with disabilities may qualify for 29 months of insurance coverage under COBRA. Questions should be directed to the human resources or personnel department of the previous employer or the Texas Department of Insurance (TDI) Consumer Help Line at 1-800-252-3439.

Medicaid

Medicaid is a joint federal/state entitlement program that pays for medical care on behalf of certain groups of low-income persons. Eligibility is based on income and assets.

Medicare

Medicare benefits are available to persons who are receiving Social Security income, who are disabled or who have permanent kidney failure.

PART A – Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and, after a hospital stay, for inpatient care in a skilled nursing facility, for home care by a home health agency or hospice care by a licensed and certified hospice agency. Some recipients are required to pay a monthly premium. However, all recipients are required to pay a deductible for each benefit period.

PART B – Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance. Part B will pay for certain inpatient services if the beneficiary does not have Part A. Recipients are required to pay a monthly premium set by Congress.

Some Medicare recipients with a very low income and few assets may qualify for state assistance in paying health care costs. Two programs are available. The "Qualified Medicare Beneficiary" (QMB) program pays Medicare's premiums, deductibles, and coinsurance for older and disabled persons who are qualified for Medicare Part A. The "Specified Low-Income Medicare Beneficiary" (SLMB) program pays the Medicare Part B premium only. Call the local Social Security Office to check on entitlement.

Texas HIV Medication Program

This is the official AIDS Drug Assistance Program (ADAP) for the state. The program is operated by the Bureau and provides medications approved by the Food and Drug

Administration for the treatment of HIV disease, illnesses caused by HIV, and other opportunistic infections in HIV-infected individuals as prescribed by their doctor. The program is operated through a network of participating pharmacies.

Texas Health Insurance Risk Pool

The Texas Health Insurance Risk Pool does not allow the use of state or federal funds, including Ryan White Title II and State HIV Health and Social Services funds, to purchase health insurance through the risk pool. Contractors who have private money available from donations or fund raising may use that money to pay for an individual to join the Texas Health Insurance Risk Pool. The contractor must be able to prove that the money used to pay the premium was not from a state or federal source. Call the TDI Consumer Help Line for information about the Risk Pool.

Texas Healthy Kids Corporation (THKC)

Texas Healthy Kids Corporation (THKC) is a public/private initiative to make affordable health insurance available to more than 1.3 million uninsured Texas children. The program is aimed at helping families to qualify for Medicaid if the family earns too much or does not have access to dependent health coverage. Policy benefits are designed for children age 2-17. Call the TDI Consumer Help Line for information on coverage.

Insurance portability

When a person moves from a large employer to a "small" employer (ranging from 2 to 50 employees) there is usually a waiting period for coverage of pre-existing conditions in the new employer's insurance plan for a maximum of 12 months. With insurance portability, when an individual changes health plans as a result of moving to a new job, the waiting period under the new plan will be reduced by one month for every month the individual was covered in the old health plan. The client should discuss insurance portability with the new employer to determine if there is a waiting period.

THHIO PAYMENT TABLE

The following is the key for abbreviations used in the table:

P - Premium amount **A** - Amount to cover primary insured person **B** - Amount to cover spouse/partner beneficiary **C** - Amount to cover child(ren) beneficiary(ies)

INFECTED FAMILY MEMBER IS THE:	and the primary insured person pays entire health insurance premium:	and the company pays the premium to cover the primary insured person:
primary insured, no spouse, partner or children,	THHIO pays the premium for the primary insured.	THHIO makes no payment.
primary insured with uninfected spouse and children,	THHIO pays the premium for the primary insured.	THHIO makes no payment. (See example 1)
primary insured's spouse or partner or when insurance coverage for spouse is ordered by court in divorce decree. No children beneficiaries,	**P** — **A** (uninfected) = THHIO payment	**P** — **A** (uninfected) = THHIO payment (See example 2)
child either living with the uninfected primary insured or in custodial care of the other spouse and covered due to court order or voluntarily. No spouse beneficiary in family,	**P** — **A** (uninfected) = THHIO payment (See example 3)	**P** — **A** (uninfected) = THHIO payment *
primary insured and spouse or partner,	THHIO pays the premium up to the monthly limit.	**P** — **A** = THHIO payment
primary insured and children when uninfected spouse/partner is present,	**P** — **B** (uninfected) = THHIO payment	**P** — **A & B** (uninfected) = THHIO payment
primary insured, spouse/partner and child(ren, or primary insured, spouse and child(ren) by court order,	THHIO pays the premium for all beneficiaries up to the monthly limit. (See example 4)	**P** — **A** = THHIO payment *
primary insured person with uninfected partner beneficiary,	**P** — **B** (uninfected) = THHIO payment	THHIO makes no payment.

* The balance is not to be prorated by the number of children beneficiaries

THHIO PAYMENT EXAMPLES

Example 1- Single family household - Primary insured person infected

Joe Doe's family consists of himself (the primary insured person), his wife and their eight year old child. All of them are covered on a common health insurance policy. Joe Doe is HIV infected but his wife and child are not. Joe's premium is $200 per month for insurance to cover the entire family. However, the company pays for Joe's portion of the insurance premium. Therefore, no payment may be made from THHIO for Joe's portion of the health insurance premium cost. Joe is responsible for the remainder of the insurance premium cost.

Example 2- Two person family - Spouse or partner infected

Joe Doe's family consists of himself (the primary insured person) and his wife. Both of them are covered on a common health insurance policy. Joe's wife is HIV infected but Joe is not. Joe's premium is $155 per month for insurance to cover he and his wife. The company paid $75 for Joe's portion of the insurance premium. Joe would have had to pay an additional $80 to cover his wife. Therefore, a payment of $80 may be made from THHIO for the spouse's portion of the health insurance premium cost.

Example 3 - Four member family - Child infected

Joe Doe's family consists of himself (the primary insured person), his wife, an eight year old child and a 10 year old child. All of them are covered on a common health insurance policy. Joe's 10 year old child is HIV infected but he, his wife and eight year old child are not. Joe must pay $200 per month for insurance to cover the entire family. Had Joe been single he would have paid $80 for himself. He pays an additional $75 to cover his wife for a total of $155. The cost of covering Joe and his wife is subtracted from the total family premium of $200. A payment of $45 may be made from THHIO for the child's portion of the health insurance premium cost since the balance is not prorated by the number of children covered by the insurance. Joe is responsible for the remainder of the insurance premium cost.

Example 4 - Three member family - Primary insured, spouse and child infected

Joe Doe, the primary insured person, is HIV infected. He and his wife were recently divorced and she was given custody of their mutual child, both of whom are also HIV infected. In the divorce decree the court ordered Joe to continue carrying the two as beneficiaries on a health insurance policy for which he must pay all premiums. Joe pays $200 per month for the policy. He would have to pay $95 for himself, $55 to cover his ex-wife and $50 to cover their mutual child. The family is found eligible for assistance under THHIO. The cost of $200 for covering all beneficiaries is the payment amount that may be made from THHIO since Joe is responsible for paying the entire health insurance premium cost.

DATE OF LAST REVIEW:
October 10, 2003 Prepared final. No public comments received.

REVISIONS

Page 1, line 29	corrected authority citation
Page 2, line 25	deleted the word “Consortia” and added the word “Assemblies” after the word “HIV” and before “are expected”
Page 2, line 28	deleted the word “Consortia” and added the word “Assembly” as the first word of the sentence
Page 2, line 33	deleted the word “Consortia” and added the word “Assemblies” as the first word of the sentence
Page 2, line 36	deleted the word “Consortia” and added the word “Assembly” as the last word of the sentence
Page 4, line 2	deleted the bulleted text: “the Bureau’s HIV Health Options to Promote Employment (HOPE);” This program is being abolished and no long accepts new enrollees
Page 4, line 31	deleted the word “Consortia” and added the word “Assemblies” as the first word of the sentence
Page 4, line 38	removed the phrase “A Consortium” and added the phrase “An Assembly” as the first word of the sentence
Page 4, line 41	deleted the word “Consortium” and added the word “Assembly” after the words “available, the” and before the words “may contract”
Page 5, lines 32-44	removed the reference to: “HIV HOPE--Texas Department of Health” from the bulleted list. This program is no longer accepting new enrollees
Page 5, lines 32-44	deleted the reference to: “Medication Reimbursement Initiative--Texas Department of Health” from the bulleted list. This program is no longer in existence
Page 6, line 43	deleted entire section “HIV Health Options to Promote Employment (HOPE)” and accompanying text. This program is no longer accepting new enrollees.
Page 7, line 5	deleted entire section “Medication Reimbursement Initiative” and accompanying text. This program is no longer in existence.
Page 7, line 21	changed the number “two” to “2”
Page 7, line 25	changed the number “two” to “2”